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ALERT

Section 111 Bulletin: House Introduces Section 111 Reform Bill—If Enacted, Would Remove SSN Reporting Obligation, Create Safe Harbor Reporting Practices and Require Earlier Notice to Insurers of Final Amount Owed Medicare

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On March 14th, Representatives Murphy (R-PA) and Kind (D-WI) introduced H.R. 1063, the Strengthening Medicare and Repaying Taxpayers Act of 2011 (SMART Act), which, if enacted, would implement many insurance industry-requested reforms to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). Because the proposed legislation would address a number of serious difficulties posed by the current Medicare Secondary Payer (MSP) system for insurers, they would likely welcome the proposed changes; however, some of the bill's provisions are likely to meet strong opposition by the Administration as impractical, thus hindering the chances for passage of the bill. The Centers for Medicare & Medicaid Services (CMS), the agency tasked with implementing Section 111, will surely oppose the bill as unworkable in practice and carrying too high a price tag. In addition, H.R. 1063 was split referred to the House Ways and Means and the Energy and Commerce Committees, which decreases the likelihood of passage as a stand-alone bill. There is no Senate companion at this time.

Reform Redux-Last March, Representative Murphy introduced a similar bill, H.R. 4796, the Medicare Secondary Payer Enhancement Act of 2010, in the 111th Congress. That bill acquired 35 cosponsors, but Congress took no formal action. It too was referred to both the

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Ways and Means and Energy and Commerce Committees. We highlight differences between the bills below.

The principal provisions of the SMART Act are as follows:

1. Requirement for CMS to Provide Amount Owed to Medicare Before Settlement-The bill would permit Responsible Reporting Entities (RREs) or Medicare beneficiary claimants to request the final "conditional payment" reimbursement amount owed to Medicare 120 days before an anticipated settlement, judgment, award or other payment. CMS would be required to respond to the request within 65 days by providing a statement of the reimbursement amount. If CMS failed to respond within that period, the RRE or claimant would need to provide a second notice. If CMS then failed to respond within 30 days of the additional notice, the government would *waive* its claim to repayment absent a showing of exceptional circumstances. This provision has changed substantially since its introduction in H.R. 4796, arguably making it less onerous on CMS through inclusion of the new "second notice" requirement and the addition of the "exceptional circumstances" clause.

Currently, there is a regulatory process by which the Medicare Secondary Payer Recovery Contractor (MSPRC) provides a beneficiary, and other parties authorized by the beneficiary, with either a Conditional Payment Letter (CPL) or Conditional Payment Notice (CPN) and then a Final Demand Letter that identify first an initial and then a so-called final amount previously paid by Medicare for medical items and services related to a claimant's alleged injury. Absent is any statutory time period during which these letters must be provided. Similarly, there is, at present, no statutory requirement that the Final Demand Letter actually represent Medicare's final request for reimbursement of conditional payments given that the MSP statute and MSP regulations permit CMS to pay health care providers and suppliers up until the date of the insurer payment to the Medicare beneficiary, or arguably until CMS receives notice of such payment. Current law therefore permits CMS to recover 100% of its conditional payments. H.R. 1063 would scale back this government right and, in doing so, redefine what it means at some level to be a primary payer.

In summary, the language proposed in H.R. 1063 would benefit both insurers and beneficiaries by definitizing and thus reducing their conditional payment exposure, as well as expediting settlement proceedings. As a practical matter, however, given the sometimes glacial pace of MSPRC activity, this new provision likely would favor private parties and frustrate MSPRC actions designed to preserve the Medicare Trust Fund. In the face of growing budgetary pressures, particularly in the public healthcare sector, it may be difficult to secure passage of a measure making it more difficult for CMS to recoup conditional payments from insurers and beneficiaries.

2. Safe Harbors-Another provision of the new bill, like last year's bill, would require CMS to develop safe harbor best practices by which RREs would shield themselves from Section 111 noncompliance sanctions. Section 111 currently states that RREs "shall be subject to a civil money penalty of $1,000 for each day of noncompliance with respect to each claimant." 42 U.S.C. § 1395y(b)(8)(E)(i). The bill directs CMS to solicit safe harbor proposals and promulgate regulations adopting specific safe harbors that would shield RREs from such arguably mandatory penalties where they have undertaken "good faith efforts to identify a beneficiary." This provision would be especially helpful to the insurance industry, which continues to struggle with the

unwillingness of some claimants to provide RREs with the required personal information necessary for Section 111 querying and reporting. Absent Congress's passage of a statutory requirement that compels a Medicare beneficiary to share his or her Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN) with an RRE, the need for a safe harbor provision is paramount.

3. Elimination of SSN/HICN Reporting-The bill proposes, as did the bill in 2010, that, within one year of enactment, insurers no longer be required to collect or report a claimant's SSN or HICN. The HICN is a Medicare-specific number assigned to all Medicare beneficiaries that adds an alpha identifier to the beneficiary's or, in a few cases, a spouse's SSN.

Although difficulty in obtaining SSNs and HICNs from claimants has presented one of the biggest obstacles to Section 111 compliance for insurers, any proposal to do away with the reporting of SSNs and HICNs is likely to face strong Agency opposition. CMS has represented on numerous occasions that the Agency must have a beneficiary's SSN or HICN in order to process insurer reports and match claimants to Medicare enrollees in the current Medicare database that stores beneficiary eligibility information, known as the Common Working File. The database cannot identify a Medicare beneficiary through mere possession of an individual's name, date of birth and gender. Absent an appropriation to fund what may be an expensive and time consuming redesign of the Common Working File maintained by contractors at nine host sites around the country, the Administration will likely argue that eliminating the requirement for SSNs and HICNs would prevent the identification of Medicare beneficiaries and frustrate the purpose of Section 111 mandatory insurer reporting.

4. Statute of Limitations-The bill also would add a 3-year statute of limitations for a government action for reimbursement of conditional payments under the MSP statute or for an action to assess penalties under Section 111. While last year's bill contained a similar limitations period for a suit to recover conditional payments, H.R. 1063 adds a limitations period that requires the government to serve notice of its intention to impose a noncompliance penalty not later than three years after an RRE was obligated but failed to report the payment in question.

Although CMS's right to recoup conditional payments is well-settled, the statute of limitations governing MSP actions is in dispute. In *United States v. Stricker*, No. 9-2423 (N.D. Al. filed Dec. 1, 2009), the court noted that the MSP statute was silent as to a deadline by which the federal government must file a claim for recovery in court and turned to the statute of limitations found in the Federal Claims Collection Act (FCCA) for actions founded upon a tort, not the statute for actions founded upon contract. 28 U.S.C. § 2415(a) and (b)(2010). Without legislative action such as that proposed here, the statute of limitations issue is likely to be litigated in future enforcement actions. The proposed 3-year statute of limitations in H.R. 1063 would resolve many questions concerning the length of time that CMS has to bring enforcement actions against insurers, Medicare beneficiaries and beneficiaries' counsel for recoupment of conditional payments, as it draws no distinctions between cases founded upon tort or contract.

H.R. 1063 does not, however, address current limitations on CMS's right to make earlier non-litigative requests for repayment and thus ultimately to initiate litigation. The MSP statute states that the government may seek to recover conditional payments from an a non-group health plan (NGHP) if the government's "request for payment is submitted" to the insurer "within the 3-year period beginning on the date on which the item or service was furnished." 42 U.S.C. § 1395y(b)(2)(B)(vi). This provision, which inures to the benefit of an insurer, was largely ignored in *Stricker*, as it was relegated to a footnote in the government's opposition brief characterizing the provision as "[limited to] claims made pursuant to employer group health plan contracts." The government's description of the provision, however, is not supported by the plain language of the section of the MSP statute within which the provision falls.

Under that section of the statute, CMS's right to request repayment from NGHPs is limited to the amounts Medicare paid within the prior three years beginning on the date on which the medical item or service was furnished. 42 U.S.C. § 1395y(b)(2)(B)(vi). This provision, which comports with commercial reimbursement practices among health insurers and providers/suppliers, is not, strictly speaking, a statute of limitations as it does *not* address CMS's right to file suit. Under this provision, CMS cannot sue an insurer if the Agency does not first make a repayment demand that comports with Section 1395y(b)(2)(B)(vi). It therefore would be beneficial to insurers to recognize Section 1395y(b)(2)(B)(vi) in defining the government's right to sue an insurer under the MSP statute.

5. Threshold Reporting Amounts-Another provision of H.R. 1063 would require CMS both to calculate and to publish annually a threshold amount below which RREs would not have an obligation to report payment of settlement or judgment amounts. CMS would be tasked with calculating a threshold amount high enough to permit the government to collect more in conditional payments than the "average cost of collection" determined by the Chief Actuary for CMS. This bill differs from last year's bill that set the threshold at not more than $5,000. In addition, the new bill does not purport to change an RRE's status as the primary payer of the Medicare beneficiary's medical items or services, despite the fact that the RRE need not report its payment to Medicare.

6. RRE Right of Appeal-Like the bill in the last Congress, the SMART Act would require CMS to draft regulations that would grant an insurer a right that current law does not explicitly provide-the right to appeal CMS's determination of the amount of conditional payments for which the insurer must reimburse Medicare.

Wiley Rein will continue to monitor this legislation, as well as all matters related to Section 111 reporting. Please contact our Section 111 Team with any questions.

Our Section 111 Team routinely covers the Section 111 NGHP teleconferences held monthly by CMS, and we send periodic Alerts to our clients addressing notable town hall discussions and other Section 111 developments. We also maintain a searchable electronic database of town hall transcripts back to October 2008. Please let us know if you would like more information about any of the Section 111 topics discussed in this Alert. You may access our Section 111 webpage and other Section 111 Bulletins and articles we have published at www.wileyrein.com/section111.

Shawn Bone and Peter Jenkins also contributed to this Bulletin.